State/Territory: Iowa

10. DENTAL SERVICES

Dental services, as defined in 42 CFR 440.100, are covered for children and adults and must be medically necessary for the prevention, diagnosis and treatment of dental disease or injuries. Dental services are limited to one thousand dollars ($1,000.00) per enrollee per state fiscal year (July 1 – June 30). The $1,000 limitation does not apply to the following services: preventive, diagnostic, emergent, anesthesia in conjunction with approved oral surgery codes or fabrication of removable dentures. The following limitations also apply to dental services but may be exceeded based on medical necessity. Children under 21 years of age are eligible for medically necessary dental services in accordance with federal early and periodic screening, diagnostic, and treatment (EPSDT) requirements.

A. *Preventive services.*

a. Oral prophylaxis, including necessary scaling and polishing. *Limitation:* Once in a six-month period except for persons who, because of physical or mental disability, need more frequent care.

b. Topical application of fluoride. *Limitation:* Once in a 90-day period. (This does not include the use of fluoride prophylaxis paste as fluoride treatment.)

c. Pit and fissure sealants. *Limitation:* Covered on first and second deciduous and permanent molars only for children through 21 years of age and for others who have a physical or mental disability that impairs their ability to maintain adequate oral hygiene.

B. *Diagnostic services.*

a. Comprehensive oral evaluation. *Limitation:* maximum of 1 every 3 years per dentist.

b. Periodic oral examination. *Limitation:* maximum of 2 per 12 months, 6 months apart.

c. Full mouth radiograph survey consisting of a minimum of 14 periapical films and bitewing films. *Limitations:* Once in a 5 year period, except when medically necessary to evaluate development, and to detect anomalies, injuries and diseases. Full mouth radiograph surveys are not payable under the age of six.

d. Supplemental bitewing films. *Limitations:* Once in a 12-month period.

e. Single periapical films, intraoral radiograph, occlusal, extraoral radiograph, posterior-anterior and lateral skull and facial bone radiograph, survey film, temporomandibular joint radiograph, and cephalometric film when medically necessary.

C. *Restorative services.*

a. Treatment of dental caries in those areas which require immediate attention. *Limitation:* Restoration of incipient or nonactive carious lesions are not covered.

b. Amalgam alloy and composite resin-type filling materials. *Limitation:* Once for the same restoration in a two-year period. An amalgam restoration is covered following a sedative filling in the same tooth only if the sedative filling was placed more than 30 days previously.

c. Stainless steel crowns are covered when a more conservative procedure would not be serviceable. *Limitation:* Stainless steel crowns with a resin window are limited to anterior teeth.

d. Laboratory fabricated crowns. Prior authorization is required. *Limitation:* Noble metals are limited to individuals who are allergic to all other restorative materials.

e. Cast post and core, post and composite or amalgam in addition to a crown. *Limitation:* Covered if a tooth is functional and the integrity of the tooth would be jeopardized by no post support.

D. *Periodontal services.* Full mouth debridement is covered once every 24 months and is not allowed on the same date of service when prophylaxis or other periodontal services are provided. Periodontal treatment procedures require prior authorization.

E. *Endodontic services.* Covered when there is a fair to good prognosis for maintaining the tooth. Endodontic retreatment requires prior authorization.

F. *Orthodontic services.* Covered for a severe, handicapping malocclusion. Prior authorization is required. *Limitation:* Not covered for enrollees 21 years of age and over.

G. Reserved

H. *Prosthetic services.*

a. An immediate denture or a first-time complete denture including six months' post-delivery care when provided to establish masticatory function. *Limitations:* Immediate and first-time complete dentures are covered only once following the removal of teeth it replaces.

b. Removable and fixed partial dentures require prior authorization. *Limitations:* A missing anterior tooth must have adequate space for replacement with a partial denture. Partial dentures replacing missing

posterior teeth are not covered when there are at least eight posterior teeth in occlusion. Fixed partial dentures are covered only for members who have a physical or mental condition that precludes the use of a removable partial denture, or who have a full denture in one arch and a fixed partial denture replacing posterior teeth is required to balance occlusion in the opposing arch.

c. Replacement dentures. Limitations: Replacement of immediate, complete, removable and fixed partial dentures requires prior authorization and is limited to once in a five-year period. Prior authorization may be obtained if replacement is medically necessary prior to the expiration of the five-year period. Prior authorization is also allowed for more than one denture replacement per arch within five years when the member has a medical condition that necessitates thorough mastication. Replacement due to resorption is not covered.

d. Relines. *Limitation*: Chairside relines and laboratory processed relines are covered only once per prosthesis every 12 months.

e. Tissue conditioning. *Limitation*: Covered twice per prosthesis in a 12-month period.

f. Repairs. *Limitation*: Only two repairs per prosthesis are allowed in a 12-month period.

g. Obturator. *Limitation*: For surgically excised palatal tissue or deficient velopharyngeal function of cleft palate patients.

h. Adjustments to a complete or removable partial denture. *Limitation*: If medically necessary after six months' post-delivery care.

I. *Implants.* Covered when a conventional denture cannot be used due to missing significant oral structures as a result of cancer, traumatic injuries, or developmental defects such as cleft palate. Prior authorization is required.

J. *Treatment in a hospital.* Covered only when the mental, physical, or emotional condition of the patient prevents the dentist from providing necessary care in the office.

State/Territory: Iowa

RESERVED